

Retiree Medical and/or Dental Coverage Change Form

(revised 9/1/2011)

Send this form only if you wish to cancel Medical and/or Dental coverage on one or more of your dependent(s).

I wish to drop the dependents listed below from my current City of Tucson group **medical** plan effective the last day of the month of _____, 20____. (Effective dates must be *prospective*. They may not be *retroactive*. For example, if the COT Benefits Office receives your form in July, you may drop coverage effective the following August 1st or later.)

Dependent's Name (printed legibly): _____

Dependent's Name (printed legibly): _____

Dependent's Name (printed legibly): _____

I understand that the dependent(s) listed above will not be permitted to rejoin a City medical plan except during Open Enrollment or due to a qualifying life event, subject to eligibility. Deadlines exist. Please see the Insurance Handbook at www.tucsonaz.gov/enroll for details.

I wish to drop the dependents listed below from my current City of Tucson group **dental** plan effective the last day of the month of _____, 20____. (Effective dates must be *prospective*. They may not be *retroactive*. For example, if the COT Benefits Office receives your form in July, you may drop coverage effective the following August 1st or later.)

Dependent's Name (printed legibly): _____

Dependent's Name (printed legibly): _____

Dependent's Name (printed legibly): _____

I understand that the dependent(s) listed above will not be permitted to rejoin a City dental plan except during Open Enrollment or due to a qualifying life event, subject to eligibility. Continuous coverage requirements and deadlines exist. Please see the Insurance Handbook at www.tucsonaz.gov/enroll for details.

Retiree's Name (printed legibly): _____

Retiree's Signature: _____

Retiree's Social Security Number: _____

Retiree's address: _____

Retiree's phone: _____

Retiree's E-mail: _____

Date signed: _____

Your social security information is considered confidential and will not be sold, shared or provided to any person or organization for marketing, sales, or for any other purpose not related to discontinuing medical coverage. It is for the sole use of the City of Tucson.

Please return your form to:

City of Tucson Benefits Office
255 W. Alameda, 5th Floor, PO Box 27210
Tucson, AZ 85726-7210

Phone: 520-791-4597 FAX: 520-791-5942